KenGen STAFF RETIREMENT BENEFITS SCHEME
P. 0. BOX 47936 – 00100 – NAIROBI

0711 035355/ 0711 036298/ 0711 036917

MEDICAL COVER PREMIUM - DEDUCTION AUTHORITY FORM

I, --- S/NO--------------------- ----- P. 0. BOX ----------------

POSTAL CODE ------------------ TOWN------------------------ TEL: --------------------is a pensioner with KenGen STAFF RETIREMENT BENEFITS SCHEME.

I hereby give irrevocable authority to the BOARD OF TRUSTEES to be deducting

Kshs. ---------------- from my monthly pension every month WITHOUT fail being medical

premium for my medical cover with------------------------------under OPTION ----------------

SPOUSE DETAILS

NAME --- ID NO. -------------------------DOB: -----------

DECLARATION

- ✓ I declare that the deductions should continue until the end of the medical cover period that is one (1) year.
- ✓ I give shall a written consent to continue or discontinue the cover when the renewal date falls due by filling a new deduction authority form.
- ✓ In case of my demise, any unpaid premium should be deducted from the pension payable to my pensionable beneficiaries.

Pensioner Signature-------------------------ID. NO.------------------------------ Date --------------

Once filled, kindly send the form via email to pensions@kengensrbs.co.ke